Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS BONE & JOINT CENTER

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-2614-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 24, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Procedure code 99080 Special Report/Work Status DWC-73 was denied in error for 'no change in work status and/or restrictions; reimbursement denied per rule 129.5.' According to the Texas State Worker's Compensation Reimbursement Guidelines separate payment is allowed for the Work Status Report – DWC-73 form CPT code 99080."

Amount in Dispute: $25.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual reviewed its claim file and found no such documented request by the Texas Mutual benefits administrator assigned to the claim, any agent, of anyone from the employer. Further, the benefits administrator documented on 10/14/13 at 1519: 'S/W [Spoke With] Arlene/Dr. Chavada, stating EE [Injured Employee] will be seen on 10/16 & approval is needed. Advised Arlene, r/n [reasonable and necessary] as it relates to the injury & all bills are subject to retrospective review. WM' (Attachment) There is no diary note documented for 10/30/13. Even if it is interpreted that the contact on 10/14/13 included any treatment by the requestor, one can clearly see the DWC73 was not 'approved' by the benefits administrator. No payment due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 30, 2013	99080-73	$25.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §129.5 sets out the guidelines for Work Status Reports.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC-W1 – Workers Compensation State Fee Schedule Adjustment
   - 248 – DWC-73 in excess of the filing requirements: No change in work status and/or restrictions; reimbursement denied per rule 129.5
   - CAC-W3 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal
   - CAC-18 – Exact duplicate claim/service
   - 350 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal
   - 878 – Appeal (request for reconsideration) previously processed. Refer to rule 133.250(H)

Issues

1. Did the requestor complete the DWC-73 in the form and manner prescribed by the Commission?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §129.5 "(c) The doctor shall be considered to have filed a complete Work Status Report if the report is filed in the form and manner prescribed by the Commission, signed, and contains at minimum: (1) identification of the employee's work status; (2) effective dates and estimated expiration dates of current work status and restrictions (an expected expiration date is not binding and may be adjusted in future Work Status Reports, as appropriate, based on the condition and progress of the employee); (3) identification of any applicable activity restrictions; (4) an explanation of how the employee's workers' compensation injury prevents the employee from returning to work (if the doctor believes that the employee is prevented from returning to work); and (5) general information that identifies key information about the claim (as prescribed on the report)."

   Per 28 Texas Administrative Code §129.5 "(d) The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee."

   Review of the submitted documentation finds that the requestor submitted insufficient documentation to support meet the documentation requirements outlined in 28 Texas Administrative Code §129.5 (d). As a result, the requestor is not entitled to reimbursement for CPT code 99080-73.
2. For the reasons stated above, the division finds that the requestor is not entitled to reimbursement for CPT code 99080-73 rendered on October 30, 2013.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		August 13, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.